HOP-MHP

Supporting mental health professionals with lived experience in reaching disclosure decisions

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The British Psychological Society
Promoting excellence in psychology

Division of Clinical Psychology

ILLINOIS INSTITUTE OF TECHNOLOGY

HOP-MHP Team

Katrina Scior – Project Lead

Henry Clements – Lead for Development of Self-Help HOP-MHP guide

Julie Evans, Anna Hildebrand, Harriet Mills & Vivienne Smith – Postgraduate Research Students

Research Assistants – Ashley Boscoe & Siir Saydam

Stakeholder Group – recruited via DCP and DClinPsy Training Courses

HOP International Network

Lead: Pat Corrigan, Illinois Institute of Technology

Context

History of ‘Us and Them’

Challenged by several surveys

Three national surveys conducted in 2015

BPS/ New Savoy Conference

- >1300 ‘psychological professionals’ included
- 46% report feeling depressed over past week
- 70% find their job stressful

➡ Charter for Psychological Staff Wellbeing & Resilience

UCL/DCP Survey of Qualified CPs

(Tay, Alcock & Scior, in prep)

- 678 clinical psychologists
- 63% reported past or current lived experience, mainly mild to mod. depression and anxiety, but also psychosis (3.3%) and bipolar disorder (1.2%)
- 11% disclosed to no one, 38% to peers/colleagues, and 26% to employers
- Main reasons for non-disclosure: fear of being judged negatively; impact on career; shame; impact on self-image

UCL Survey of Trainee CPs

(Grice, Alcock & Scior, in prep)

- 564 clinical psychologists in training
- 67% reported lived experience, of these 29% current, again mainly anxiety & depression, but also psychosis, BD and BPD
- Disclosure to course staff and/or clinical supervisor least likely
- “Feel I will be seen negatively by course staff if they are aware I am struggling”

THE TIMES

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Welcome to your preview of The Times

Chances are your NHS psychologist is depressed too

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Lifestyle › Wellbeing › Health Advice

Confessions of a depressed psychologist: I'm in a darker place than my patients

Last week it was reported that almost half of NHS psychologists should be on the couch themselves - an astonishing 46 per cent suffer from symptoms of depression, according to a survey by the British Psychological Society. Here, a psychologist with substantial

What is HOP-MHP?

- A new self-help intervention for mental health professionals with lived experience designed to support decisions and actions regarding disclosure
- Adaptation of manualised group intervention *Honest, Open, Proud* (HOP)
- HOP-MHP delivered via a self-help guide alongside online peer support
- Stage 1 of HOP-MHP: HOP for Clinical Psychologists and Psychological Practitioners

Contents of HOP-MHP

Retained HOP Structure - three sessions:

1. Considering the Pros and Cons of Disclosing
2. Different ways to Disclose
3. Telling your Story

➢ Follow-up and What's Next

Aims of HOP-MHP

- To support mental health professionals in considering disclosure related decisions
- To reduce self-stigma, stigma stress and disclosure related distress associated with mental health problems and ‘dual status’, and promote sense of empowerment
- To challenge stigma within the mental health professions and within society

Outcomes

Mostly in line with pilot study of HOP by Rüsch et al. (2014)

1ary outcomes:

- Stigma stress**
- Clinical Outcomes in Routine Evaluation (CORE-10, as measure of psychological distress)

2ndary outcomes:

- Disclosure related distress*
- Secrecy*
- Perceived benefits of disclosure / reasons for staying in*
- Disclosure of Lived Experience
- Coming Out with Mental Illness Scale
- Self-stigma (adapted version of SSMIS-SF)
- Empowerment (full Rogers 28 item scale)

UCL HOP-MHP Study

- Stage 1 (March ‘16 – May ‘17): Planning of Study, Development of HOP-MHP Self-help guide, Identification of Measures, Setting up of Web Peer Forum

- Stage 2: Small pilot (June – July ’17) (N=5): Assess acceptability and feasibility
  August 2017: revise guide and measures in line with feedback

- Stage 3: Pilot RCT (Sep – Dec ‘17) (N=50) - Collect preliminary outcome data & process data

  (Sample size calculation based on Rüsch HOP pilot RCT results for stigma stress)

At all three stages, recruitment includes trainee and qualified clinicians, and wherever possible other mental health professions

Stakeholder Input

- Stakeholder group recruited via 2015 survey disseminated via DCP

- HOP-MHP Stakeholder Day Nov 2016 – Team + 12 stakeholders

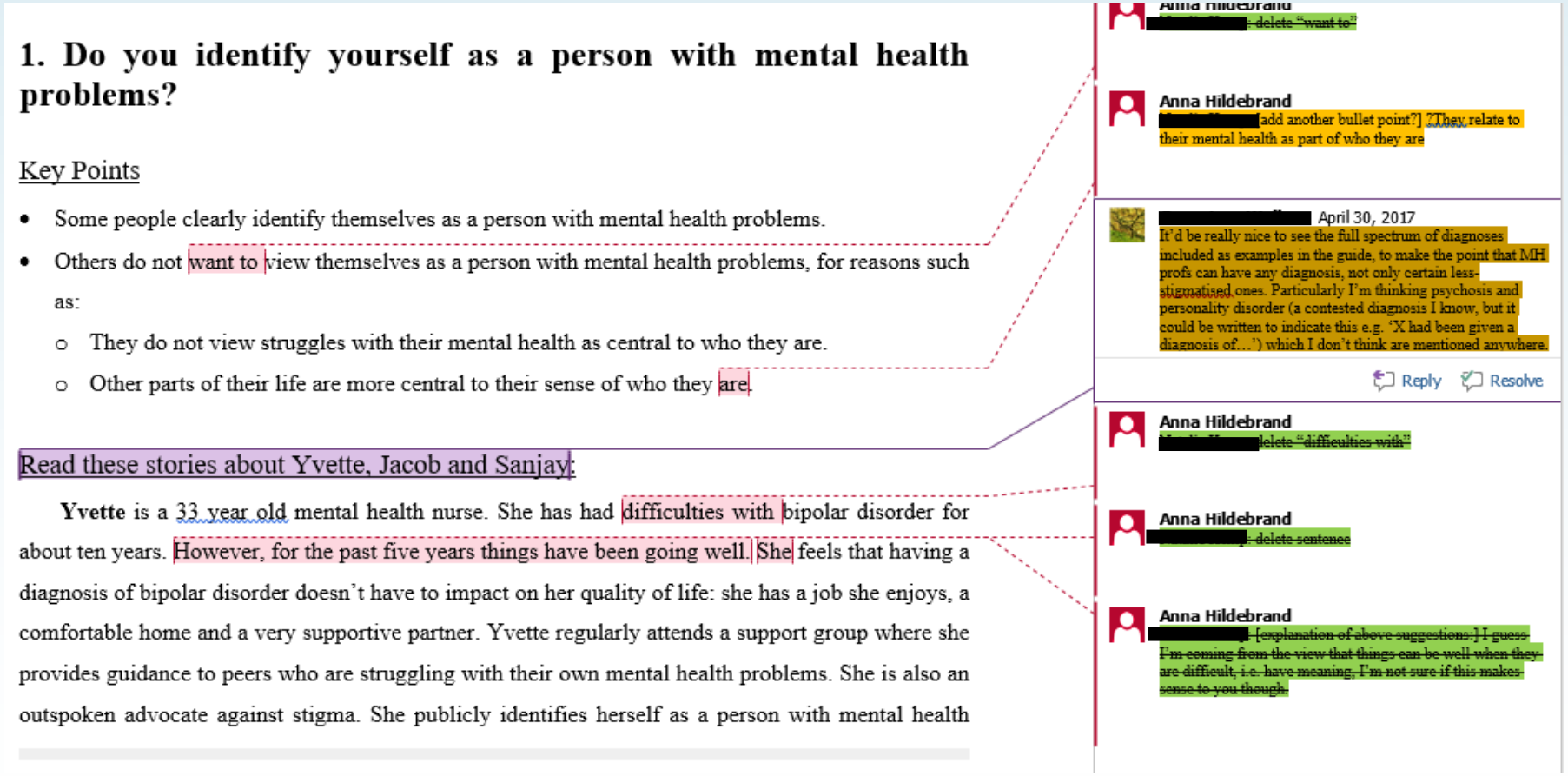
  Main focus:

  - Discuss central objectives of HOP-MHP
  - Review HOP manual in detail with view to adaptation
  - Review plan for evaluation and outcome measures

- Since: In-depth review of new HOP-MHP self-help guide by six stakeholders

Stakeholder Input to Self-help Guide

Stakeholder Comments on Excerpt from Session 1



1. Do you identify yourself as a person with mental health problems?

Key Points

- Some people clearly identify themselves as a person with mental health problems.
- Others do not want to view themselves as a person with mental health problems, for reasons such as:
  - They do not view struggles with their mental health as central to who they are.
  - Other parts of their life are more central to their sense of who they are.

Read these stories about Yvette, Jacob and Sanjay:

Yvette is a 33 year old mental health nurse. She has had difficulties with bipolar disorder for about ten years. However, for the past five years things have been going well. She feels that having a diagnosis of bipolar disorder doesn't have to impact on her quality of life: she has a job she enjoys, a comfortable home and a very supportive partner. Yvette regularly attends a support group where she provides guidance to peers who are struggling with their own mental health problems. She is also an outspoken advocate against stigma. She publicly identifies herself as a person with mental health

Anna Hildebrand
[redacted]: delete "want to"

Anna Hildebrand
[redacted] add another bullet point?] ?They relate to their mental health as part of who they are

[redacted] April 30, 2017
It'd be really nice to see the full spectrum of diagnoses included as examples in the guide, to make the point that MH profs can have any diagnosis, not only certain less-stigmatised ones. Particularly I'm thinking psychosis and personality disorder (a contested diagnosis I know, but it could be written to indicate this e.g. 'X had been given a diagnosis of…') which I don't think are mentioned anywhere.

Reply Resolve

Anna Hildebrand
[redacted] delete "difficulties with"

Anna Hildebrand
[redacted]: delete sentence

Anna Hildebrand
[redacted] [explanation of above suggestions:] I guess I'm coming from the view that things can be well when they are difficult, i.e. have meaning. I'm not sure if this makes sense to you though.

Stakeholder Comments on ‘Weighing the Pros and Cons of Disclosing’

Finally, some people might experience family anger about disclosing their mental health problems, for example a relative might say: “*I didn't want everyone to know about your mental health problems. Now, people are asking me questions that I don’t want to answer*”. Families have their own stories about mental health problems and struggles with stigma, which will be affected by your decision to disclose.

Weighing the costs and benefits of disclosing

Using Table 1.3 below, make a list of all the costs and benefits of disclosing from your own perspective. (We suggest you use the longer version of this table (Worksheet 1.3) available in the Appendix.) Benefits represent why you would do it, what you expect to happen that is positive as a result of disclosing to others. Costs are why you wouldn’t do it, the negatives or harm that could result from disclosing.

Volunteer1

[redacted]: I wonder if it is worth adding an additional Cost or including in one of the existing ones the difficulty of office dynamics e.g.: the way colleagues speak about service users with mental health difficulties. I think this is a significant factor in MHP not disclosing: when colleagues complain about how difficult it is to work with “PD” clients for example or use “PD” as shorthand for “difficult” clients, or laugh about some service user experiences. While we know this may often be a way to relieve tension or manage the difficulties of supporting service users, it can be a real hindrance to disclosure. I guess this may be about changing dynamics in the office and colleagues feeling fearful of what they say or being judged, as well as person disclosing fearing judgement etc.?

HONEST, OPEN, PROUD

To Eliminate the Stigma of Mental Health Problems

A Self-Help Guide for Mental Health Professionals

Katrina Scior, Henry Clements, Anna Hildebrand, Harriet Mills, and Patrick W. Corrigan

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You might also want to think about how to discuss current experiences related to your mental health problems such as leaving work early once a week to see a therapist. For example, you might plan responses to the following types of questions:

"Why do you have to leave at 4pm every Tuesday?"
"How come you never drink alcohol at company parties? Are you teetotal?"

Without answers, these observations may stick out for some colleagues or acquaintances. Friends and family members who are familiar with your experiences may need to be aware of your answers so they know what to say and not to say to colleagues or other people in your life to whom you do not choose to disclose, for example: *"I told some of my colleagues that I pick up my niece from school every Tuesday rather than telling them about being in therapy. I would appreciate it if you could back me up when they we meet them at our annual staff and partners party."*

For some people, these acts of commission are a disadvantage: *"Why do I have to hide the fact that I experience mental health problems?"* It can be even harder to ask family members or friends to do the same. As a result, you may choose not to change or add to your story. However, filling in the gaps can be a way of refocusing your story on information that will not lead to stigmatising responses from others.

3. Selective disclosure

When you keep your experiences with mental health problems private, it may be difficult to access the support and resources of others. To address this problem, some people disclose their mental health problems to selected colleagues or friends. If you disclose, you may find people who are empathic and supportive towards you, for example: *"Now that I have told my manager*

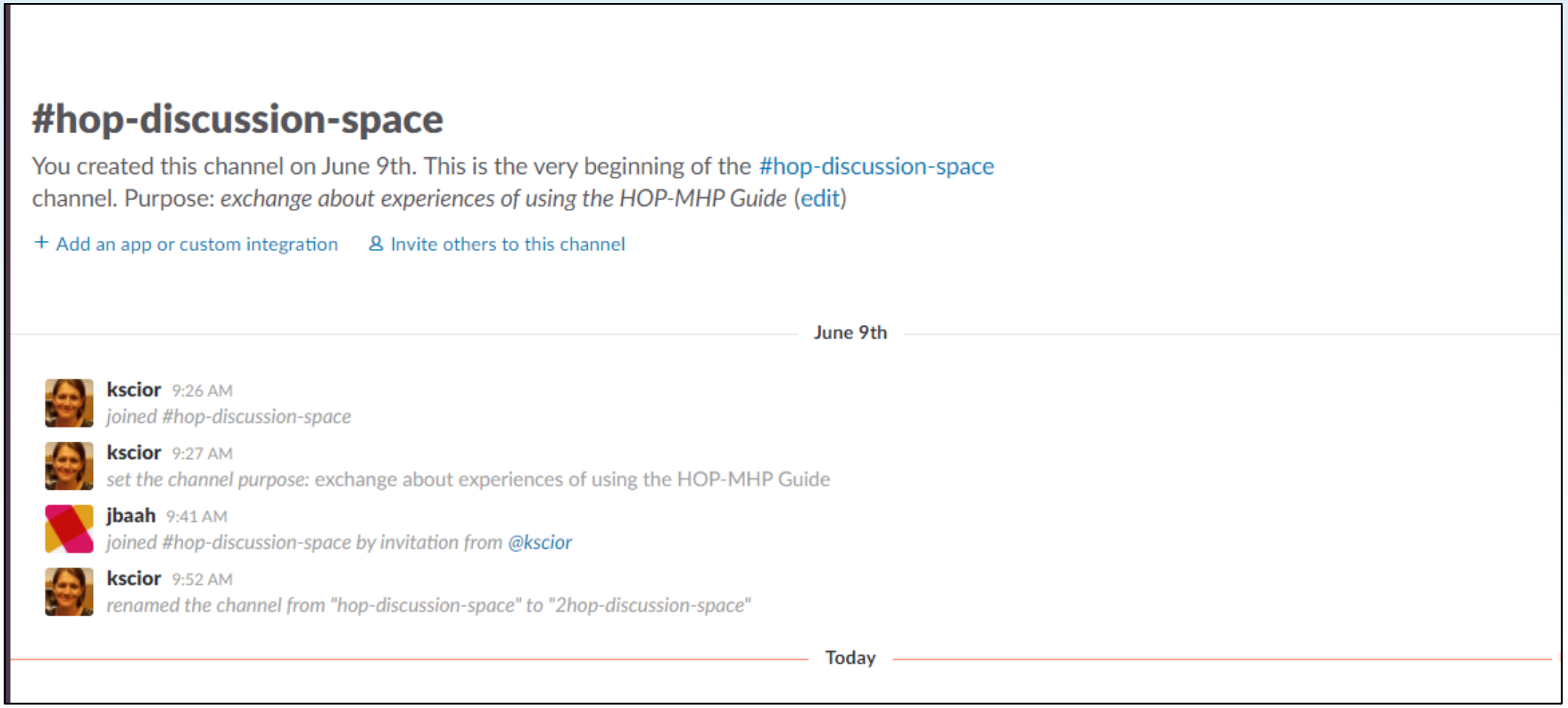
Key Changes

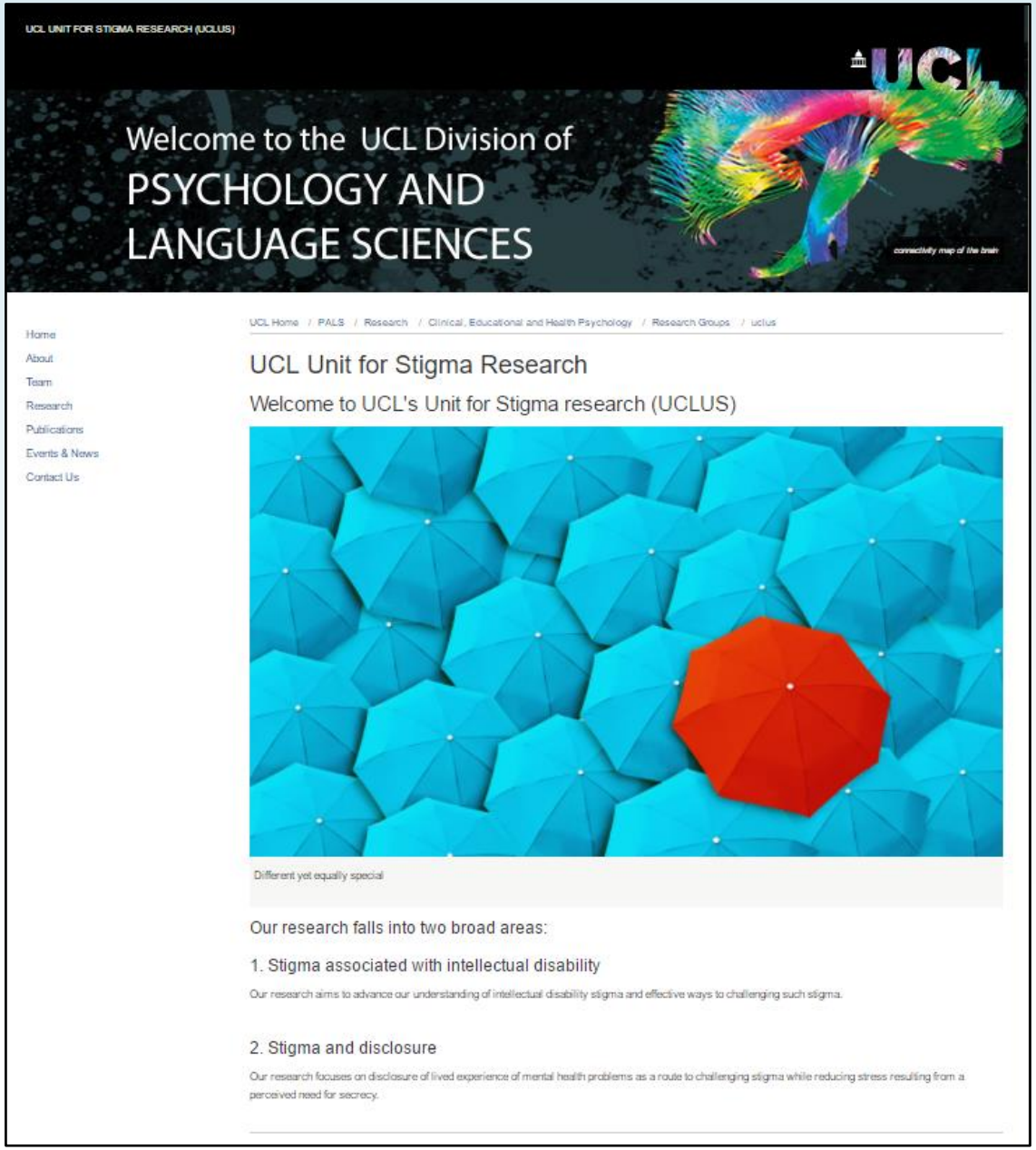
- Written as self-help guide
- Preface expanded substantially – added sections on ‘Language’ and ‘Theory’, plus evidence for key messages
- All references to mental illness reworded to mental health problems
- Case examples, Quotations and 1st person accounts rewritten to represent mental health professionals
- Session 2: ‘Secrecy’ renamed ‘Keeping it Private’

Delivery of Self-Help Guide

- Recruitment via professional organisations, networks and training courses –email, advertisements, talks, and blog posts
- Once signed up - Completion of baseline survey
- Sent HOP-MHP guide with weekly reminders
- In parallel given access to HOP-MHP closed peer forum (moderated by 2 members of research team)
- After 3 weeks asked if completed guide – if yes, directed to T2 survey (if not given extra week)
- 3 weeks later sent follow-up sessions
- On completion of these directed to T3 survey and telephone interviews with subsample
- Follow-up at 6 months by T4 survey and telephone interviews with subsample

HOP-MHP Web Peer Forum (anonymous sign-up and postings)





Dissemination about HOP-MHP and access to information and sources of support via website of UCL Unit for Stigma Research (UCLUS) –
Core Team of 7
Plus 13 Postgrad Research Students

Internal launch July 2017
External launch early 2018

Future Plans

Expand implementation and evaluation of HOP-MHP by:

- Working in partnership with other applied psychology and therapy professionals, Royal College of Psychiatrists, Royal College of Nursing, IAPT Programme

- And 3rd sector organisations – Time to Change, Mental Health Foundation (tbc)